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The role of nurses in providing patient care is both instrumental and expressive. Fulfillment of these dual roles depends on the psychosocial and physical well-being of nurses. This study examined the stress experience of nurses in Hong Kong. Various factors affecting the experience of stress and the coping strategies adopted were also investigated. Female nurses (N=196) working in different specialities were studied. Irrespective of their work experience, nursing grades and nature of work, the major source of stress experienced was found to consist of intrapsychic conflict which arose from the profession, the organization, the job, and their home. The total stress experienced also correlated positively with job dissatisfaction. In coping with these stresses, interpersonal succorance seeking was most frequently used. These findings show significant deviations from those obtained in the West. The nature of this stress-coping relationship was evaluated in relation to the nursing profession and the characteristics of the Chinese culture. (Author)

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NURSING STRESS AND COPING PATTERNS

IN

HONG KONG

BY

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ABSTRACT

The role of nurses in providing patient care is both instrumental and expressive. Fulfillment of these dual roles depends on the psychosocial and physical well-being of nurses. This study examined the stress experience of nurses in Hong Kong. Various factors affecting the experience of stress and the coping strategies adopted were also investigated. 196 female nurses working in different specialties were studied. Irrespective of their work experience, nursing grades and nature of work, the major source of stress experienced was found to consist of intrapsychic conflict which arose from the profession, the organization, the job and their home. The total stress experienced also correlated positively with job dissatisfaction. In coping with these stresses, interpersonal succorance seeking was most frequently used. These findings show significant deviations from those obtained in the west. The nature of this stress-coping relationship is discussed in relation to the nursing profession and the characteristics of the Chinese culture.

NURSING STRESS AND COPING PATTERNS IN HONG KONG

Introduction

The role of nurses in promoting the psychosocial well-being of patients has long been recognized. The well-being of nurses themselves, however, have not received much attention until the recent decade. The success or failure with which nurses perform their instrumental and expressive nursing roles depends to a large extent on nurses' own physical and psychological well being. An understanding of the nature and the magnitude of the stress experienced by nurses and their subsequent coping mechanisms is therefore essential.

Up to now, research in this area has mostly been conducted in the west, especially in the United States. A review of the literature indicates that nursing stress has been studied from three major perspectives: (a) as a form of occupational stress; (b) as stresses unique to the profession of nursing; and (c) as stresses resulting from multiple role demands from the feminist perspective.

Nursing stress as occupational stress:

Nursing stress has been studied within the framework of occupational stress (Hingley and Cooper, 1986). Similar to other occupations or professions, the stress of nursing is considered to arise from certain aspects of the job. Cooper and Marshall (1976) proposed a 'six elements model' to account for these stresses, and posits that stress of nurses arise from:

a) factors intrinsic to the job, eg. working conditions,

workload and shiftwork,

b) the role in the organization, eg. role conflict and role ambigulty,

c) relationship at work, eg. relationship with superiors, subordinates and colleagues,

d) opportunities for career development ,

e) organizational structure and climate, and

f) extra-organizational factors.

Nursing stress as unique to the profession of nursing:

Marshall (1980) employing a managerial and administrative perspective, questioned the validity of applying principles developed in the study of occupational stress to the profession of nursing. To her, the nursing profession incorporates several distinctive features which warrant separate consideration. Firstly, the primary task of nurses was noted to be highly anxiety-provoking. Conceptualizing stress as the perception of threat (Lazurus, 1966), nursing care of patients can be seen as constituting a fundamental threat to nurses at two levels: as a skilled worker whose competence to heal is on trial, and more fundamentally, as a human being who is herself vulnerable to the illnesses and death she is nursing. Secondly, the unequivocal nature, high visibility, and importance of success and failure in nursing work distinguishes this occupation from others which measure performance on more ambiguous criteria. Thirdly, there are sanctions in the profession of nursing against showing symptoms of stress. Nurses are expected to maintain a detached concern and remain calm even during emergencies.

Other researches have focused on the 'ancillary' and 'marginal' role of nurses in the medical field (Fourcher andd Howard, 1981; Gillon, 1986). While nurses have claimed special areas of professional competence and have established standards for licensure, they have never possessed the full degree of autonomy in practice which forms the hallmark of professionalism. The status of nurses is thus low. Attempts to rectify the situation is difficult, primarily because there is nothing necessarily beneficial for patients in such a development.

Nursing stress from a feminist and sociocultural perspective:

The types and intensity of stress experienced by nurses have also been studied from a feminist perpective. The nursing role is considered similar to other caregiving roles of female in society. Nursing is seen as basically a female profession, and nurses are under social pressure to fulfill difficult and multiple caregiving obligations (Alexander, 1984). Intra- and inter-role conflict, involving potentially incompatible demands of individuals across different life domains can be easily created. Role overload is also common. This perspective locates the nature of stress experienced by nurses in the wider social arena. In particular, the relationship between the multiple roles played or expected of nurses has received much attention (Hirsch and Rapkin, 1986). The conflict between home and work demand, and the conflict between marriage and job, have been two major foci of study.

Although nursing stress is accepted as an important health issue, contributions from the east have remained scarce. There seems to exist an implicit assumption that nursing stress is a universal phenomenon, in terms of both its causes and effects. The role of culture in influencing the experience, coping and outcome of individuals under stress has not been made explicit in the literature. Social sciences research, however, suggests that the role of culture is important and a vital consideration.

One example is the stress of high-density living and its effects on the physical, psychological and social well-being of human beings. Animal studies have consistently found adverse effects of high density living on the behaviour of rats - a group of symptoms collectively known as 'behavioural sinks' (Colhoun, 1972). Similar phenomena are believed to occur in human beings (Freedman, 1975). Research done in Hong Kong (Millar, 1979), however, found very mild effects, despite the high population density here (average: over 5000 persons per square kilometres, most densely-populated area: over 160000 per square kilometres). The concept of density tolerance has been proposed to account for this finding. It is argued that certain aspects of the Chinese culture are conducive for the development of this tolerance, which facilitates coping in high-density living (Ward, 1970; Anderson, 1972; Lee, 1985).

It remains speculative whether unique cultural influences exert their effects on the experience of nursing stress. In the west, workload and interpersonal conflict have

been identified as the major stress components encountered by nurses (Gray-Toft and Anderson, 1981; Decker, 1985; Hingley and Cooper, 1986; Dewe, 1988). Decker (1985) notes that the negative relationships between the individual nurse and the head nurse and other co-workers exerts a strong and adverse effects on her satisfaction with the intrinsic aspects of the job (ability utilization, job responsibility and recognition for work), satisfaction with the extrinsic aspects of the job (advancement and pay), overall job satisfaction and conflict experience (particularly that between moral and professional judgement of patient care). Our understanding of the Chinese culture, however, suggest a less important role played by these factors in the experience of stress in Chinese nurses.

The Chinese society is a collective society. In contrast to individualistic society such as the American which values self-reliance, a collective society values interdependency and interpersonal harmony (Hsu, 1971; Ho, 1979). Collectivism affirms that the preservation and enhancement of the well-being of the group is the supreme guiding principle for social action. This basic distinction in cultural orientation has led many researchers to doubt the validity and reliability of applying western concepts or findings in the Chinese culture. One well-known example being Hsu's criticism of the concept of personality (Hsu, 1971). To Hsu, the concept of personality is a western concept rooted in individualism. The Chinese conception of man is based on the individual's transactions with his fellow human beings. This collective orientation is transmitted to the younger

generation through the process of socialization. Lam (1982) notes that the childrearing practice in Hong Kong is geared towards maintaining interpersonal harmony. From an early age, Chinese children are equipped with adequate resources to avoid interpersonal conflict in daily life. Coupled with the Chinese value of 'working hard without complaining', interpersonal difficulties and workload may constitute a lesser problem for Chinese nurses. On the contrary, the lack of emphasis on intrapsychic processes since early childhood upbringing may impose more serious consequence.

The extent of cultural factors in influencing coping behaviours is also not well documented. Studies in the west have found palliative methods to be widely practised. In a major study of over thirty-five thousand nurses in U.K., Hawkins and his colleagues (1983) note that smoking together with alcohol and caffeine intake, are the most common ways of coping with stress. In the United States, Lachman (1983) estimates that 1 to 2 percent of practicing nurses are alcoholics. In addition, the rate of narcotic addiction among nurses is 30 to 100 times greater than the general population. 'The population equivalent of ten nursing schools and three medical schools is lost each year to narcotics addiction' (Lachman, 1983, p.69). In view of the collective orientation of the Chinese culture, more collective coping methods, and interpersonal succorance seeking such as talking to other people, seeking others' support and advice, are likely to be more prevalent.

This study examines the stress experience of nurses in Hong Kong - a rapidly developing city which is situated on the southeastern coast of the Kwantung Province. There are three major foci:

(1) The relationship between nursing stress and job satisfaction;
(2) The components of nursing stress and the mediating factors; and
(3) The coping methods.

The findings of this study can hopefully throw more light on the role played by culture in the experience of stress in nurses.

METHODOLOGY

The Sample

196 female nurses were recruited from the Medical Psychology class run by the authors for nurses. The majority (85%) worked in hospital-based services (wards, outpatient clinics, operating theatres and accident and emergency department), the rest worked in nursing education (8.3%), community-based services (4.7%) and central administration (1%). 92% were between the age of twenty to forty, 8% were over forty years old. About 70% were registered nurses, 22% belonged to the N.O.2 grade and the rest N.O.1 grade. Over 25% have worked in the field for over fifteen years. (Table One)

Data collection

Subjects were asked to fill in a questionnaire comprising four sections modified from Hingley et al. (1986).

Section One: This section included questions concerning the demographic and occupational characteristics of the individual.

Section Two: This section consisted of questions relating to subjects' feeling about the job. Six statements were given and they were asked to indicate the extent to which they agreed with each statement on a 1 to 5 scale, 1 representing 'strongly disagree' and 5 representing 'strongly agree'. Summation of the scores became the Job Dissatisfaction Score, with higher scores representing less job satisfaction. In addition, subjects were asked to estimate the percentage of stress they experienced as arising from their nursing job.

Section Three: This section included 71 items identified in the literature as causing stress in nurses. They included stressors which arose as a result of the job, the profession and the work/home conflict. Subjects were asked to indicate the extent to which each factor had caused them pressure on a 1 to 5 scale, with 1 representing 'no pressure' and 5 representing 'extreme pressure'. They were also asked to give additional sources of stress which they have experienced but were not included in the questionnaire. All responses were summated and averaged for each subject to form the Stress Score.

Section Four: This section focused on the coping behaviour of the subjects. 23 kinds of coping methods were listed for the subjects to indicate how far these methods have been adopted for dealing with their stress. A scale of 1 to 5 was used, with 1 representing 'never' and 5 meaning 'nearly always'. Subjects were also asked to indicate their sources of support (family members, other relatives, friends and colleagues) in coping with stress.

Data Analysis

The Principal Component Analysis was performed on the 71 stress items with the quantimax rotation. One way analysis of variance was performed on the first six factors and on the Stress score in relation to (a) years of experience; (b) nature of work and (c) nursing grades.

Pearson's Product Moment Correlation was performed between the respective factors and the Stress and Job Dissatisfaction scores.

Frequency distributions of the use of coping methods and sources of support were calculated.

RESULTS

(1) Sources of stress

Altogether 17 factors with eigenvalue greater than 1 were produced, accounting for 70% of the total variance. The first six factors are presented here (Table Two).

Factor 1 had an eigenvalue of 23.7 and accounted for 33.4% of the total variance. It was labelled **SELF/MANAGEMENT CONFLICT** as it contained items which underscored the lack of personal autonomy and control in coping with organizational demands.

Factor 2 was labelled **HOME/WORK CONFLICT**. It contained items which focused on the role conflict and the lack of appreciation and support from the superiors.

Factor 3 was concerned with problems in **DEALING WITH FATIENTS AND RELATIVES.**

Factor 4 was labelled **WORKLOAD**. it was concerned with stress due to work overload, time pressure and deadline, staff shortages and fluctuations in workload.

Factor 5 included a group of stressors which focused on the 'lacks' - professional status, participation in decision making, promotion prospects, specialized training, job satisfaction and social life. It was thus termed **DISSATISFACTION OF JOB**.

Factor 6 was concerned with issues relating to **DEATH AND DYING**.

These six factors together accounted for 50% of the total variance.

(2) Work experience, job nature, nursing grades and the experience of stress (Table Three)

The result of the ANOVA indicated that, except for Factor 6, the different components of stress did not vary as a result of different working experience, work nature (central administration, community-based service, nurse education, accident and emergency dept., operating theatre, outpatients or clinics, wards or special units) or nursing grades (registered nurse, nursing officer 2 and nursing officer 1). These sources of stress thus seemed to arise from the general aspects of nursing care.

Nurses with different working experience and grades experienced different levels of stress. The highest level of stress was experienced by those nurses who had spent ten to fifteen years in nursing, followed by the five to ten years and

less than five years group. Those who had worked for more than twenty-five years experienced the least stress. On the other hand, registered nurses experienced the most stress, followed by the N.O. 2 grade and N.O.1 grades.

(3) Relationship between Stress and Job Satisfaction (Table Four)

a. Stress/Factor scores and Job Satisfaction

The Job Dissatisfaction score was positively correlated with the Stress score ($r=0.326$, $P<0.000$) and Factor 1 score ($r=0.24$, $P<0.005$). It was negatively correlated with Factor 3 score ($r=-0.18$, $P<0.05$).

b. Stress/Factor scores and self estimated job stress

The percentage of stress estimated by the subjects to arise from their job was positively correlated with the Stress score ($r=0.224$, $P<0.001$), Factor 1 score ($r=0.32$, $P<0.000$), Factor 4 score ($r=0.28$, $P<0.01$) and the Job Dissatisfaction score ($r=0.29$, $P<0.000$).

(4) Coping behaviours (Table Five)

The five most frequently adopted methods, in descending order, were 'talked to someone you know', 'talked to someone who could do something about the problem', 'just concentrated on what I had to do next', 'went over the problem again and again in your mind to try and understand it' and 'talked to someone about how I was feeling'. These methods were adopted by at least 80% of the subjects.

On the other hand, smoking, using tranquillizers or other medications and alcohol consumption were seldom practised. They were practised by less than 6% of the subjects.

(5) Sources of support (Table Six)

Friends were the most frequently utilized source of support (72.3%), followed by work colleagues (52.3%), spouse (45.6%), mother (23.6%), relatives (9.7%), father (5.6%), and children (2%).

DISCUSSION

On the whole, the nurses we studied experienced a moderate level of stress (mean = 2.6). The level of stress experienced was affected by the nurses' year of experience and their ranks in the hospital. The findings show that stress tends to increase in the early years of the career and reaches the peak at about ten to fifteen years. Thereafter, it decreases gradually. Registered nurses who had worked for less than fifteen years experienced the most stress. More senior nurses in Nursing Officer One grade and those who had worked for more than 25 years experienced the least stress.

The magnitude of stress experienced was also negatively related to nurses' satisfaction of their job and their estimation of the percentage of current stress attributable to their job. A higher level of stress was associated with greater job dissatisfaction and higher percentage of self-estimated job stress.

'Workload' and 'Interpersonal relationship', which have been found to be the major sources of stress for nurses in many western studies (Gray-Toft and Anderson, 1981; Hingley and

Cooper, 1986; Dewe, 1988), only accounted for 5% of the total variance. For the Chinese nurses in Hong Kong, intrapsychic conflict - the conflict between self and the organization, and between work and home demands - is much more important. These two factors together accounted for nearly 40% of the total source of stress variance.

For the first major stress factor, two different interpretations are possible. It may be the result of a lack of personal control in meeting the organizational demand or a result of the profession/bureaucracy conflict.

(a) The lack of personal control

In analysing the experience of nurses working in hospitals, Fourcher and Howard (1981) distinguished between what they termed as the personal versus the organizational rationality. The personal rationality relates to work experience that is organized in relatively unique and immediately creative ways by the individual nurse to meet with daily demands. It implies a direct involvement and control in the way the work is organized. Organizational rationality relates to work experience that is organized in relatively preestablished ways to suit the systemic requirements of a large organization. A high degree of predictability in all of its activities is required. Being an employee of the hospital, the individual nurse faces a conflict between her own rationality, ie, her own plan of action, and the organizational rationality, preset rules to execute organizational goals and maintain organizational structure.

(b) Conflict between profession and bureaucracy

Nurses are both health care professionals and employees of hospitals. They are subject to the challenge of increasing professionalism amongst their colleagues and the demands of increasing bureaucratization in their work places. While this kind of clash exists in all kinds of profession, that experienced by nurses may be particularly difficult to handle. Although nurses have claimed special areas of professional competence and have established standards for licensure, they have never possessed the full degree in practice that is often designated as the crucial factor of professionalism (Friedson, 1970, Gillon, 1986). In face of organizational demands, the professional requirements are hard to uphold. Decker (1985) found that nurses experienced tremendous conflict between the beliefs and expectations developed during the formal training process and the role definitions in the hospital setting. This situation is being complicated by the practice that in hospitals, position titles emphasize managerial functions rather than the independent functions of nursing (Alexander, 1978). Since professionalism requires autonomy and administration demands control, the conflict between the two is inevitable.

Which of these two interpretations is more plausible? It would follow from the first interpretation that nurses high in the administrative hierarchy (e.g those who belonged to the Nursing Officer One grade) would possess more power which should result in more control/involvement and less stress. Yet this was not found in the present study. Stress resulted from this

person/organization conflict was similar for nurses with different years of experience, different grades and working in different settings. This conflict is thus likely to be fundamental in nature, possibly reflecting the conflict between the nursing profession and the bureaucracy of the management.

The second major stress factor deals with the conflict nurses experienced between home and work demands. Whilst this conflict forms the focus of many studies on women's health (Haw, 1982; Warr and Parry, 1982; Thoits, 1983; Cook and Rousseau, 1984; Kandel, Davies and Raveis, 1985; Verbrugge, 1985), it has seldom been included in the research on nurses. Most research on the mental health of nurses has lost sight of the fact that nurses are also members of society. Their psychological well-being is affected by their job and the multiple roles they have to play in society. Our finding highlights this aspect of nurses' stress experience. Nurses we studied were found to be caught between the demands of home and work, with transport hazzles and the lack of appreciation from superiors making the situation doubly more difficult. Hirsch and Rapkin (1986) also found the support or rejection from the work supervisors to be a significant determinant of nurses' satisfaction of their job and their family life.

Whilst further empirical validation is necessary, our findings suggest that the stress experienced by Hong Kong nurses is mainly intrapsychic, involving the conflict between the self and the demands arising from various sources, namely, the job,

the profession, the organization (hospital) and home. To cope with these stresses, they talk to other people, mainly friends and colleagues, to express their feelings and to find out solutions to their problems. Palliative methods such as smoking, drinking and using medications are rarely adopted. These findings contrast sharply with those obtained in the west. The major sources of stress for nurses in the west are more external in nature (workload and interpersonal problems). Palliative methods are more frequently used. The role played by work colleagues is also different. For nurses in Hong Kong, work colleagues serve as a source of support. For nurses in the west, however, they constitute a source of stress. The extent to which these dissimilarities are the result of cultural differences is unknown. It is possible that the lack of emphasis of the Chinese culture on intrapsychic processes has made Hong Kong nurses more vulnerable to problems of this nature. The priority given to interpersonal harmony, on the other hand, has equipped them with adequate resources to deal with relationship problems.

CONCLUSION

This study examines the nature of stress experienced by nurses in Hong Kong. The results reveal significant deviations from the existing literature. The major sources of stress experienced by nurses in Hong Kong are intrapsychic conflicts (self versus organization and home demand versus work demand), in contrast to the more external sources of stress (workload and interpersonal relationship) experienced by nurses in the west. Coping methods also differ. Nurses in Hong Kong utilize the

interpersonal channel more frequently to seek for emotional and social support. Further research is necessary to validate these findings. Nevertheless, they highlight the need to consider cultural variables in studying stress and its related processes. In particular, nursing stress should not be conceptualized as merely an occupational stress which is isolated from the wider social and cultural arena. It is the outcome of the interaction between the individual nurse and the environment.

Table One: Demographic Characteristics

AGE

20 - 30	45.6%
31 - 40	46.8%
40 and over	7.6%

MARITAL STATUS

Single	52.1%
Married	47.9%

NUMBER OF CHILDREN LIVING AT HOME

None	64.8%
Children of preschool age	15.8%
Children of school age	17.3%
Post-school age	2.0%

NURSING GRADES

Registered nurse	68.8%
Nursing Officer Two	22.0%
Nursing Officer One	9.2%

YEARS OF EXPERIENCE

Less than 5 years	7.2%
5 - 10 years	39.2%
10 - 15 years	28.4%
15 - 20 years	16.5%
20 - 25 years	6.2%
More than 25 years	2.6%

NUMBER OF SUPERVISED STAFF

None	19.2%
1 - 5	21.5%
6 - 10	20.3%
11 - 15	6.8%
16 - 20	7.2%
21 - 25	3.4%
26 - 30	4.6%
31 - 50	6.2%
50 - 100	6.2%
over 100	4.5%

WORK SETTINGS

Central administration	1.0%
Community-based services	4.7%
Nurse education	8.3%
Accident and emergency	2.1%
Operating theatres	4.2%
Outpatient clinics	5.7%
Wards or special units	67.2%
Others	6.8%

Table Two: Principal Component Analysis of nursing stress

Factor 1: Eigenvalue = 23.7 Per. of Var.= 33.4	
Management expects me to interrupt my work for new priorities	0.7687
Organizational change	0.7456
I lack confidence in management	0.7244
Frustration with conflicting procedures	0.7083
I spend my time 'fight fires' rather than working to a plan	0.6974
Decisions or changes which affect me are made above, without my knowledge or involvement	0.6950
Conflict between my unit and others it must work with	0.6928
I don't feel adequately trained for the job I have to do	0.6861
Having problems allocating resources	0.6778
Others' demands for my time at work are in conflict	0.6755
Difficulty in dealing with passive people	0.6727
I have too little time in which to do what is expected of me	0.6668
My nursing and administrative roles conflict	0.6667
Relationships with administrators	0.6666
Others at work seem unclear about what my job is	0.6614
Avoiding conflict with superiors	0.6556
Factor 2: Eigenvalue = 2.87 Per of Var = 4.0	
I need to absent myself from work to cope with domestic problems	0.6608
Domestic/family demands inhibit promotion	0.6351
Difficulties with transport	0.5208
My superiors do not appreciate my home pressures	0.4865
Job vs home demands	0.3721
Sexual discrimination at work	0.3561
Factor 3: Eigenvalue = 2.52 Per of Var = 3.5	
Difficult patients	0.6759
Dealing with relatives	0.6026
Bereavement counselling	0.5625
Playing a leadership role	0.4041
Factor 4: Eigenvalue = 2.14 Per of Var = 3.0	
Work overload	0.6650
Time pressure and deadlines	0.6067
Staff shortages	0.5779
Fluctuations in workload	0.4887

Factor 5:	Eigenvalue = 1.87	Per of Var = 2.6
Low professional status		0.6373
Lack of participation for planning/decision making		0.5265
Lack of promotion prospects		0.4753
Lack of specialized training for present task		0.4648
Unsocial hours		0.3369
Lack of job satisfaction		0.3335
Factor 6:	Eigenvalue = 1.81	Per of Var = 2.6
Poor physical work conditions		0.6573
Exposure to death		0.5074
Involvement with life and death situations		0.4097

Table Three: Working experience, nature of work, nursing grades and sources of stress: Results of the Analysis of Variance

	F Ratios		
	Work experience	Nature of work	Grade
Factor 1	2.23	0.49	1.14
Factor 2	1.29	0.64	2.04
Factor 3	0.20	1.58	1.34
Factor 4	0.23	1.57	1.13
Factor 5	1.70	1.31	0.15
Factor 6	2.65*	3.02**	3.03*
Stress Total	3.15**	0.19	3.16*

* P<0.05, ** P<0.01

Table Four: Correlation coefficients between Stress, Self-estimated Job Stress and Job Dissatisfaction

	Job Dissatisfaction	Self-estimated Job Stress
Stress Total	0.33**	0.22**
Factor 1	0.24**	0.32**
Factor 2	0.14	0.01
Factor 3	-0.18*	0.07
Factor 4	0.06	0.28**
Factor 5	0.07	-0.07
Factor 6	-0.03	-0.05

Table Five: Coping behaviours

The most frequently adopted methods, in descending order, were

Talked to someone you know	86%
Talked to someone who could do something about the problem	84%
Just concentrated on what to do next	84%
Went over the problem again and again in mind to try and understand it	84%
Talked to someone about how I was feeling	80%
Kept feelings to self	76%
Just let the feelings out in some way	75%
Wished what happened could have been changed	67%
Use informal relaxation techniques	65%
Exercise	61%
Blamed myself	57%
Didn't let it get to me, refused to think about it too much	50%
Went on as if nothing had happened	49%
Use humour, tell jokes	47%
Leave and go elsewhere	41%
Got mad at the people or things which caused the problem	38%
Avoided being with people in general	37%
Drink coffee, coke or eat frequently	35%
Use relaxation techniques	20%
Take aspirin	6%
Have an alcolic drink	5%
Use tranquillizers or other medication	4%
Smoke	1%

Table Six: Sources of support

Category	Percentage
Friends	72.3%
Work colleagues	52.3%
Spouse	45.6%
Mother	23.6%
Relatives	9.7%
Father	5.6%
Children	2.0%

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